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Path to a High Performance Health System: Improving Value and Achieving Savings

Cathy Schoen
Senior Vice President, The Commonwealth Fund

Health Care Quality and Cost Council Annual Meeting:
Aligning Payment Reform with Outcomes
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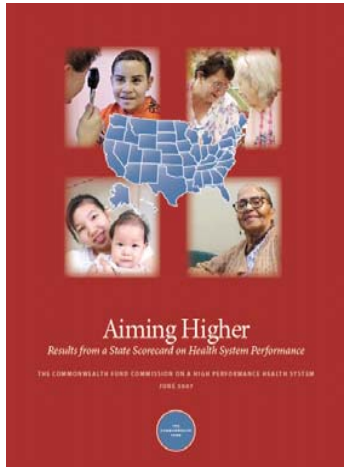
cs@cmwf.org
www.commonwealthfund.org

Commonwealth Fund Commission on a High Performance Health System

Objectives:

- **To move the U.S. toward a high performance health care system that helps everyone lead healthy, long, & productive lives**
- **A high performance health system is designed to achieve four core goals**
  - **high quality, safe care**
  - **access to care for all**
  - **efficient, high value**
  - **system capacity to innovate and improve**



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Toward High Performance Health Systems – Vision and Integrated Policies

- **What constitutes high performance? Goals?**
  - **Focus on improving population health**
  - **Pursuit of Access, Quality and Efficiency - value**
  - **Capacity to improve and innovate**
- **Vision of health care delivery system – key attributes**
- **Coherent strategies: system approach**
  - **Coverage foundation**
  - **Payment reform to align incentives with quality/efficiency**
  - **Invest in system reforms and population health**
- **Indicators (metrics) to track and monitor change and set benchmarks to improve**
- **Leadership/collaboration: goals and shared direction**

Goals for a High Performance Health System

HIGH QUALITY CARE

Effective, Coordinated, Safe, Patient-Centered

ACCESS & EQUITY FOR ALL

LONG, HEALTHY, AND PRODUCTIVE LIVES

EFFICIENT HIGH VALUE CARE

SYSTEM CAPACITY TO INNOVATE AND IMPROVE

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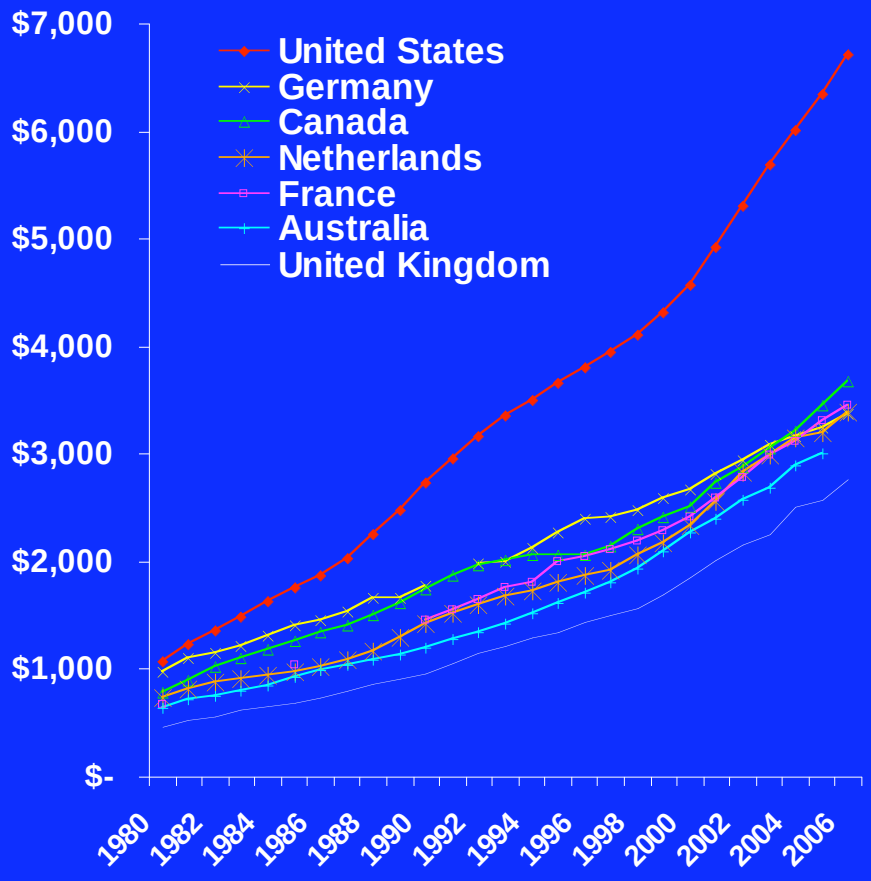
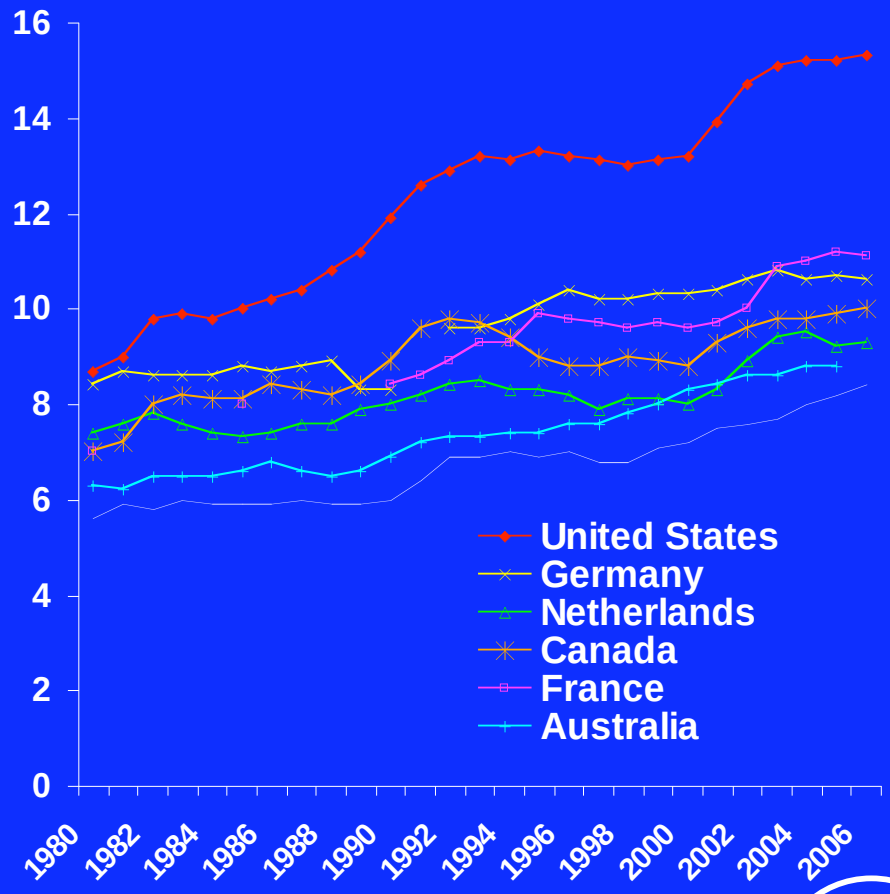
International Comparison of Spending on Health, 1980–2006

Average spending on health per capita ($US PPP*)



Total expenditures on health as percent of GDP



* PPP=Purchasing Power Parity.
Source: OECD Health Data 2008, Version 06/2008.

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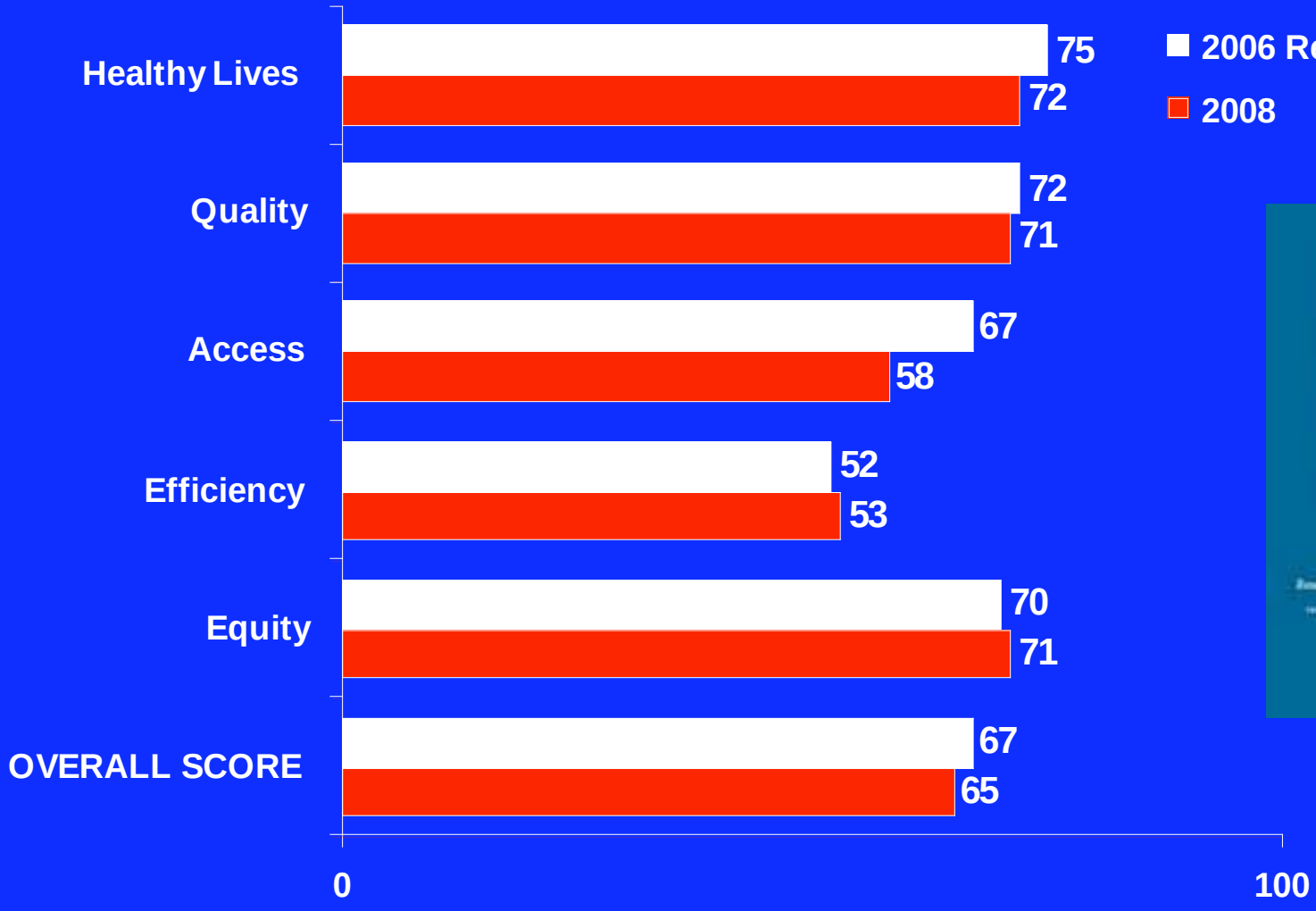
National Scorecard on Health System Performance



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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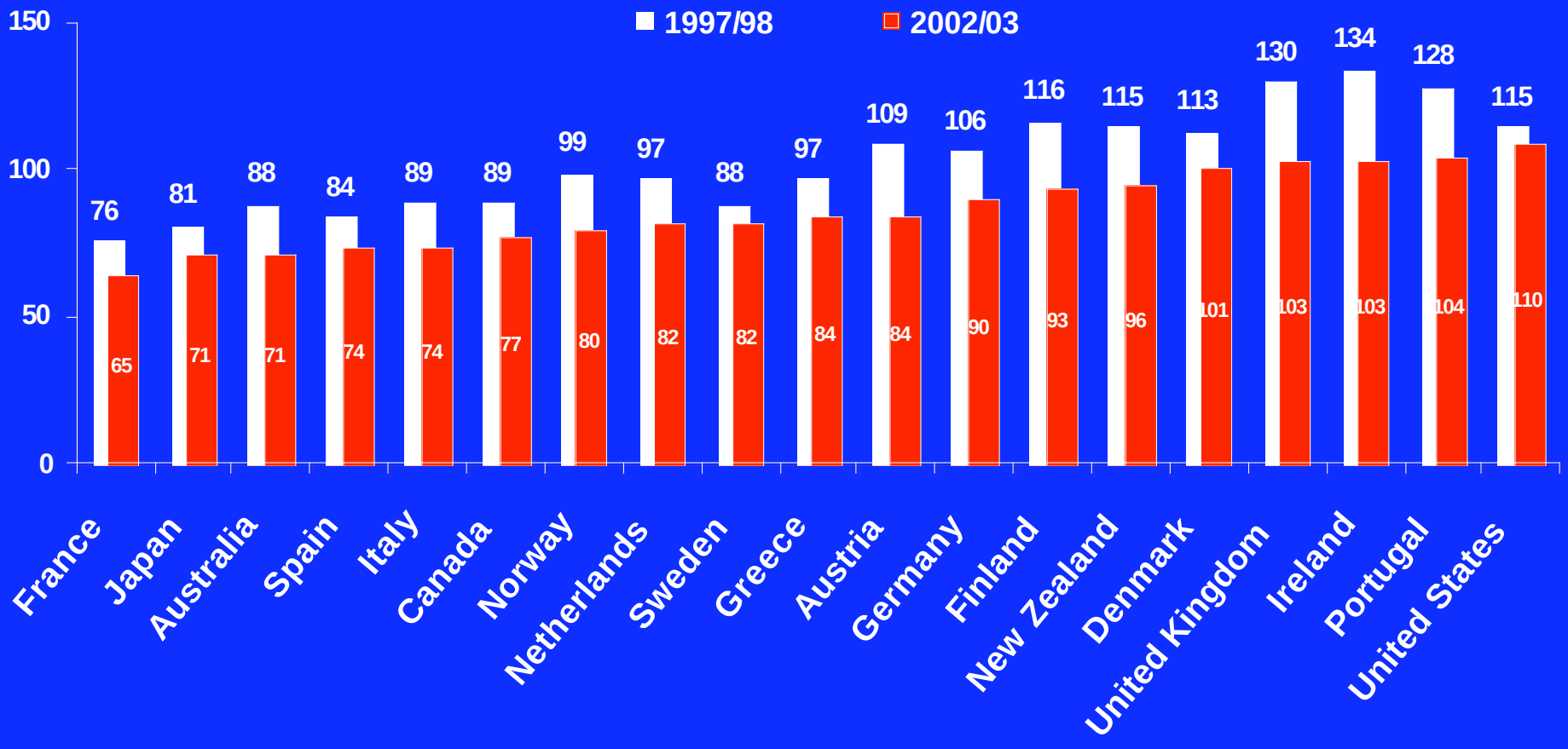
Mortality Amenable to Health Care
U.S. Rank Fell from 15 to Last out of 19 Countries

Deaths per 100,000 population *



* Countries' age-standardized death rates before age 75; from conditions where timely effective care can make a difference. Includes: Diabetes, asthma, ischemic heart disease, stroke, infections screenable cancer.
Data: E. Nolte and C. M. McKee, "Measuring the Health of Nations," Health Affairs, Jan/Feb 2008).

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

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Key Strategies for High Performance

1. **Extend affordable insurance to all**
2. **Align incentives to enhance quality and efficiency – value and savings**
3. **Organize care around the patient: accessible, coordinated, efficient**
4. **Invest in reporting, evidence-base, health information technology and population health**
5. **Leadership and collaboration to set and achieve goals – aiming higher**

Source: Commission on a High Performance Health System, *A High Performance Health System for the United States: An Ambitious Agenda for the Next President*, The Commonwealth Fund, November 2007

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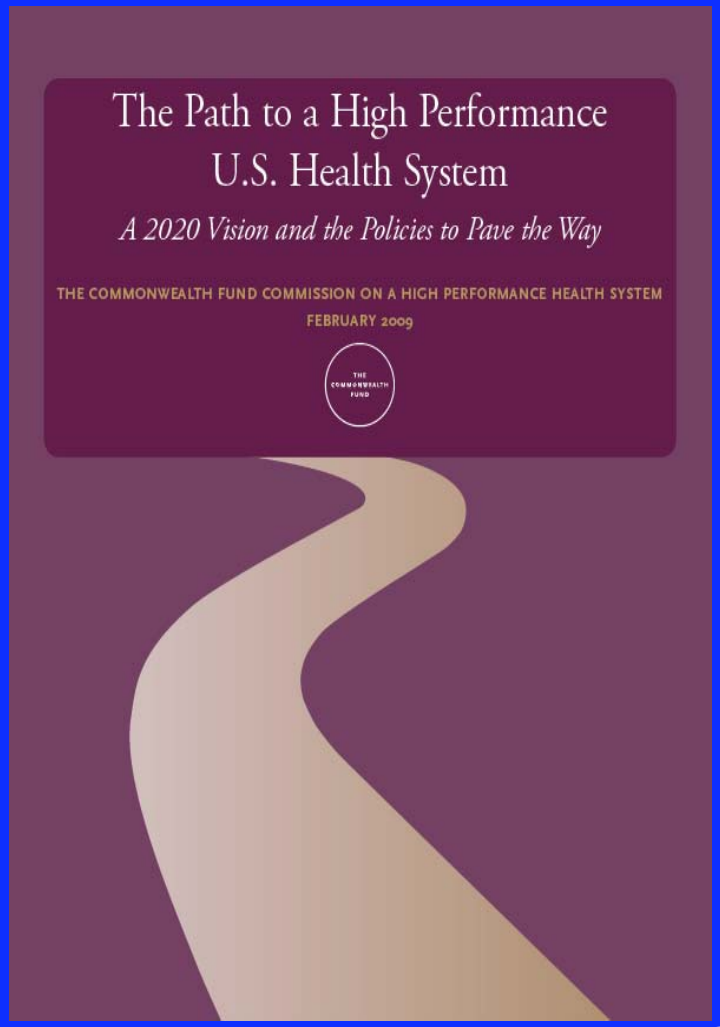
Path to High Performance: Integrated Strategic Polices

- **Insurance and access**
- **Aligning incentives with quality and efficiency**
- **Correcting price signals in health care markets**
- **Producing and using better information**
- **Promoting health and disease prevention**



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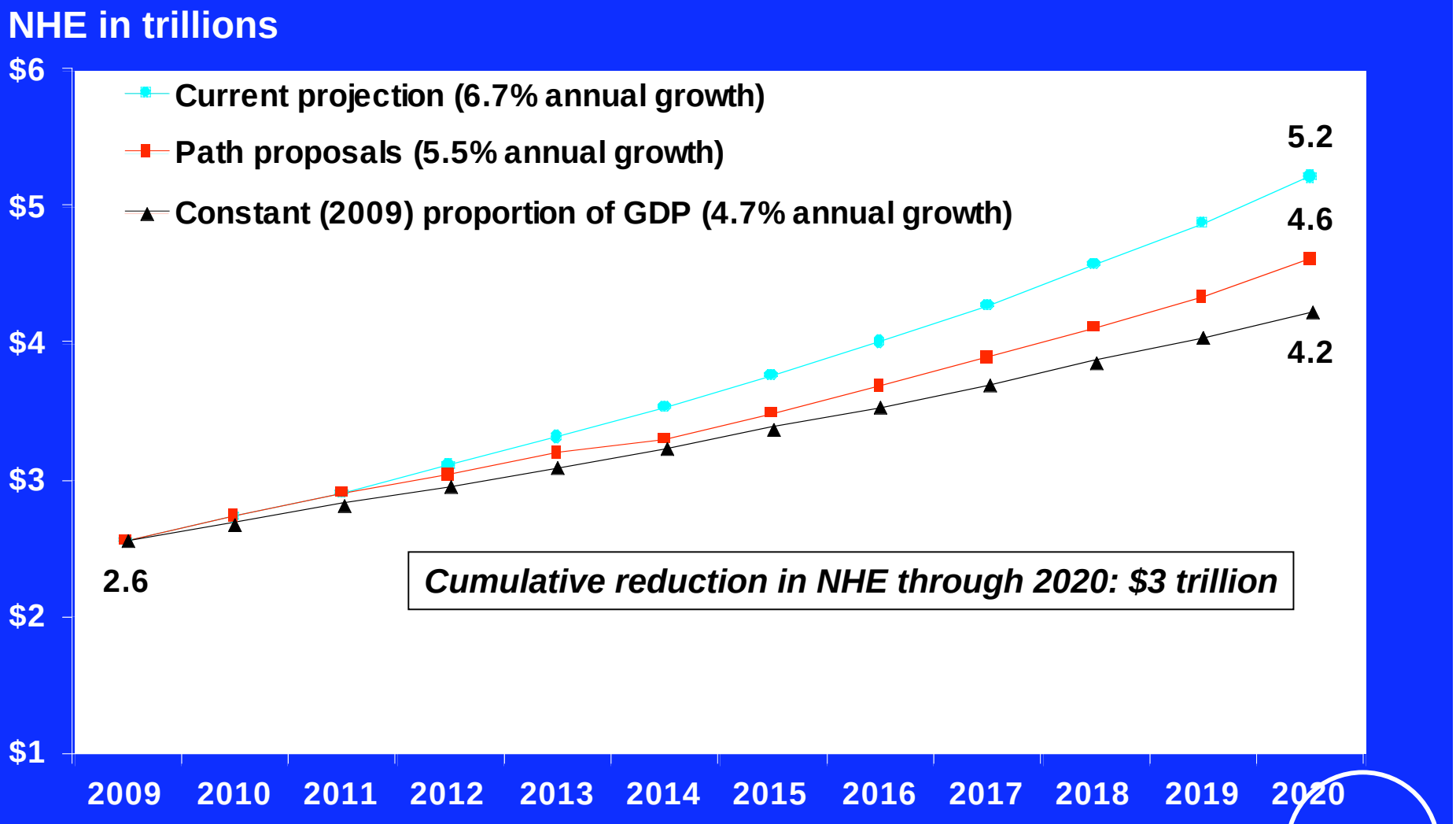
Bending the Cost Curve with High Value Return

Total National Health Expenditures (NHE), 2009–2020

Current Projection and Alternative Scenarios



Note: GDP = Gross Domestic Product.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, Feb. 2009.

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Key Attributes of High Performance Health Care Delivery Systems

- **Patients have easy access to appropriate care and information, including off-hours**
- **Clinically relevant information is available to providers at point-of-care and to patients - continuity**
- **Care is well-coordinated with smooth care transitions**
- **Providers within and across settings accountable to each other for quality and value and work together**
- **There is clear accountability for total care**
- **Care systems continuously innovate and "learn" to improve outcomes, experiences and the value of care**

Source: Shih et al. *Organizing the U.S. Health Care Delivery System for High Performance*, The Commonwealth Fund, August 2008

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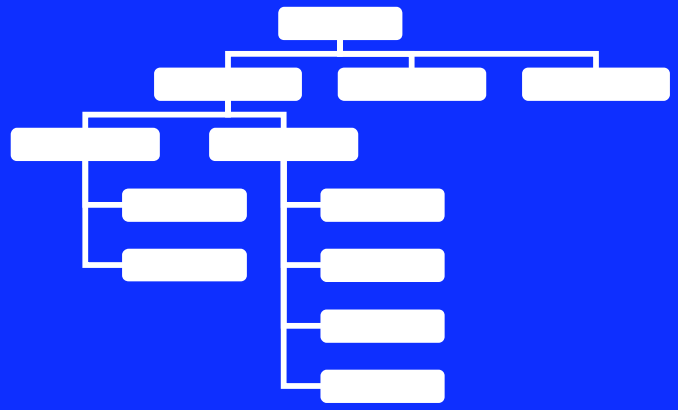
The Ways Care is Organized and Care Is Paid For Are Interrelated

- **Organizations Matter**
  - **Organizations are necessary but not sufficient for providing better, more coordinated care**



- **Payment methods**
  - **Incentives need to be aligned with performance (ultimately outcomes) not quantity of care**

See: Shih et al, *Organizing the U.S. Health Care Delivery System for High Performance*, The Commonwealth Fund, August 2008

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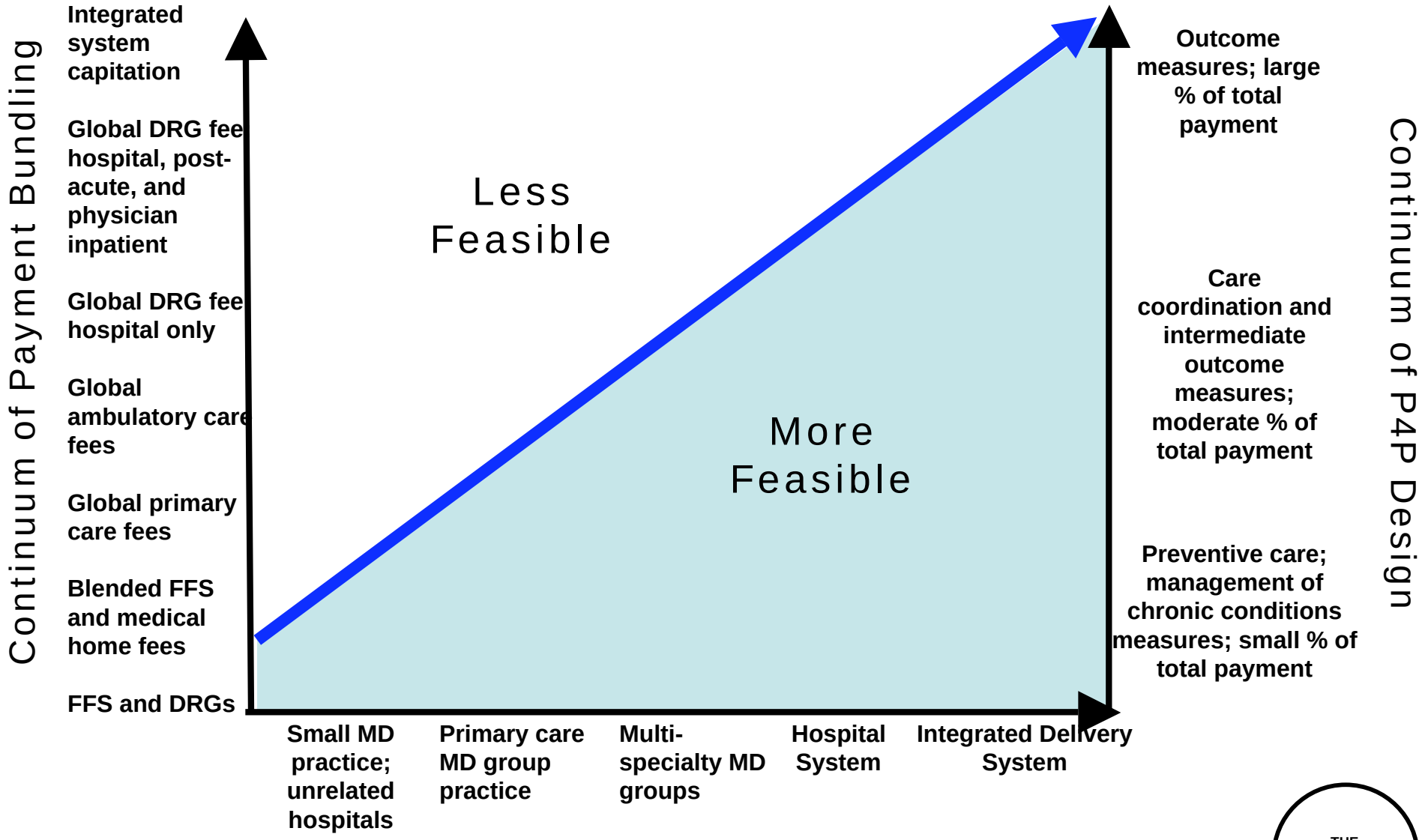
Payment Methods and Organization Are Interrelated Need Incentives and Systems for Organized Care



Source: Shih et al. *Organizing the U.S. Health Care Delivery System for High Performance*, The Commonwealth Fund, August 2008

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Accessible, Patient-Centered Primary Care Foundation Essential for Delivery System to Improve

Need for new directions

- **Lack of access and timely communication**
- **Patients report use of emergency rooms that could have been avoided if physician had been available**
- **Broad experience and frustration with poor coordination, fragmented care system**
- **No one is accountable for ensuring recommended preventive care, health, or improving control of chronic conditions**
- **Wide variation in outcomes and costs for chronically ill patients across the U.S.**
- **Primary care workforce/teams - shortages**

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Access, Coordination & Safety, 2008
U.S. Chronically Ill at High Risk

Base: Adults with chronic conditions

Percent reported in past 2 years:	AUS	CAN	FR	GER	NETH	NZ	UK	US
Access problem due to cost*	36	25	23	26	**7**	31	13	54
Coordination problem**	23	25	22	26	14	21	20	34
Medical, medication, or lab error***	29	29	18	19	**17**	25	20	34

*Due to cost, adult did NOT: fill Rx or skipped doses, visit a doctor when had a medical problem, and/or get recommended test, treatment, or follow-up.

**Test results/records not available at time of appointment and/or doctors ordered test that had already been done.

***Wrong medication or dose, medical mistake, incorrect diagnostic/lab test results, and/or delays in abnormal test results.

Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.

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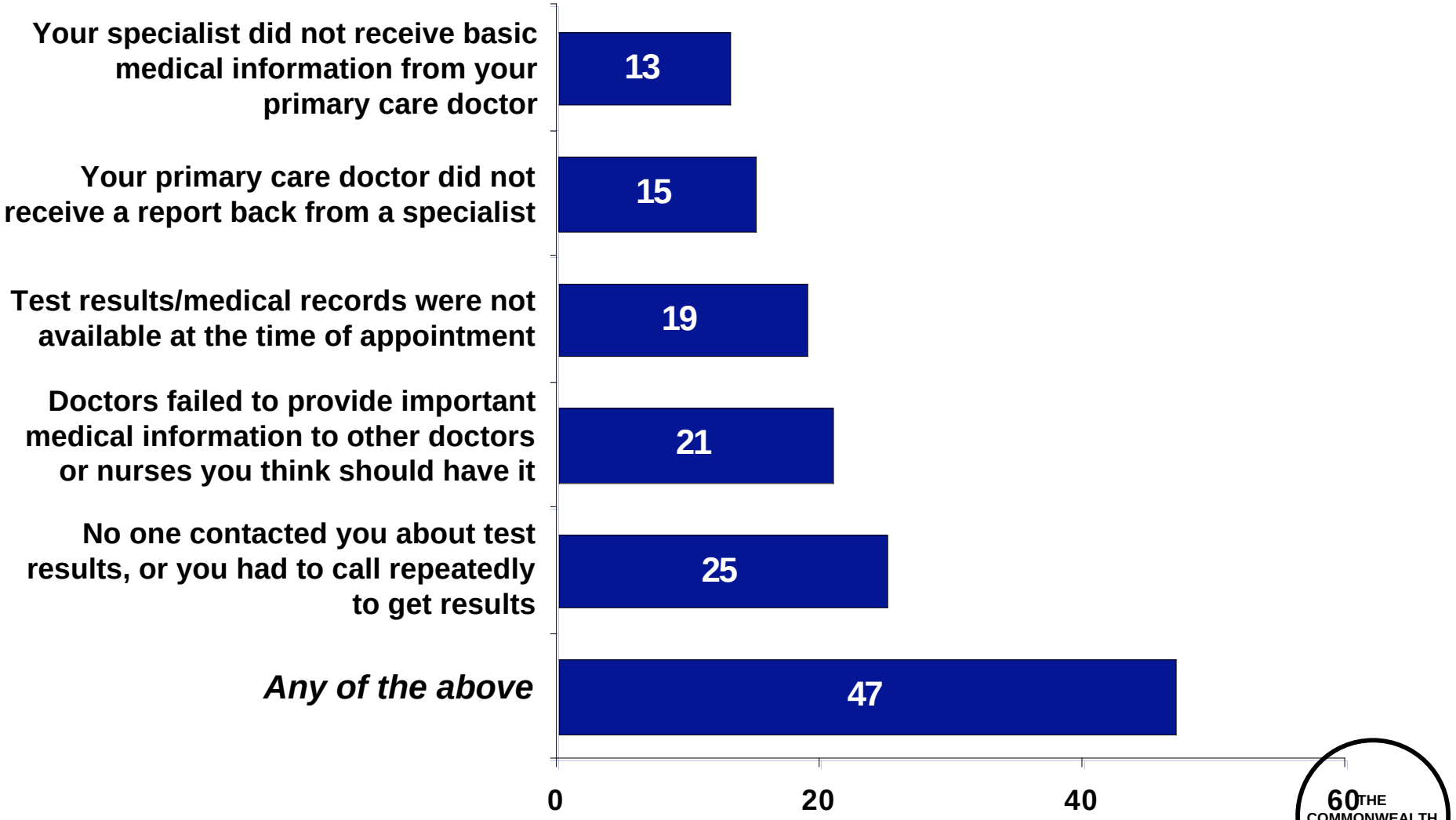
Poor Coordination: Nearly Half of U.S. Adults Report Failures to Coordinate Care

Percent U.S. adults reported in past two years:



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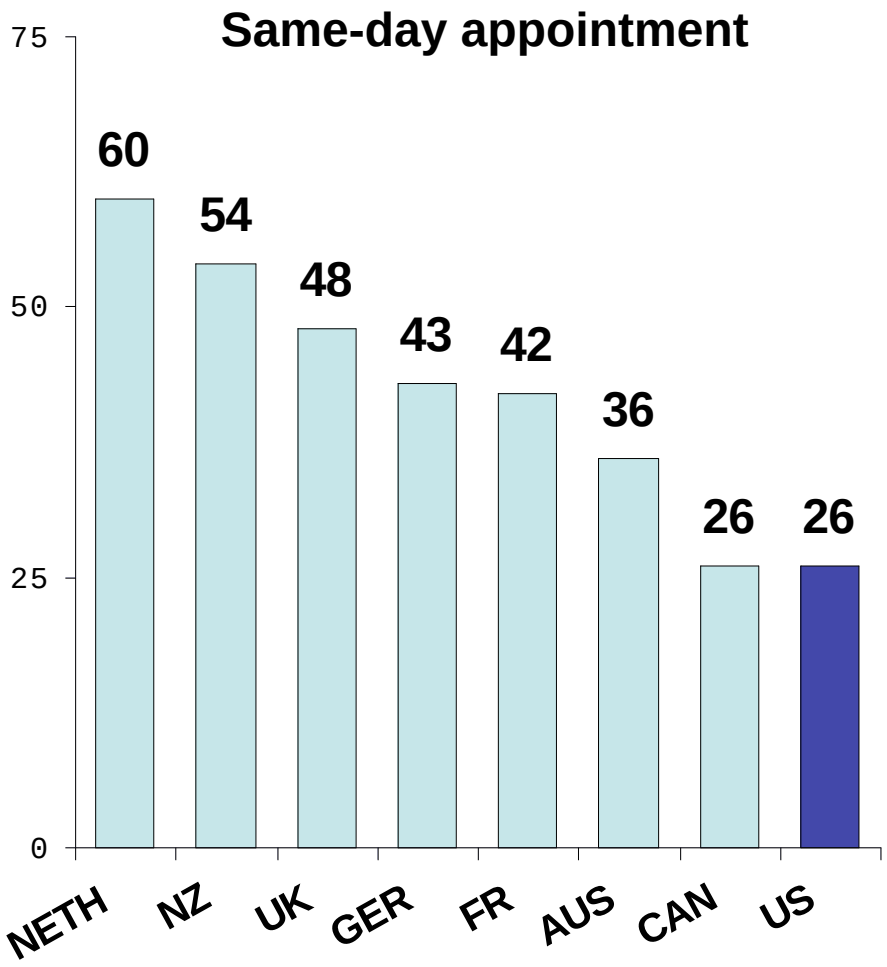
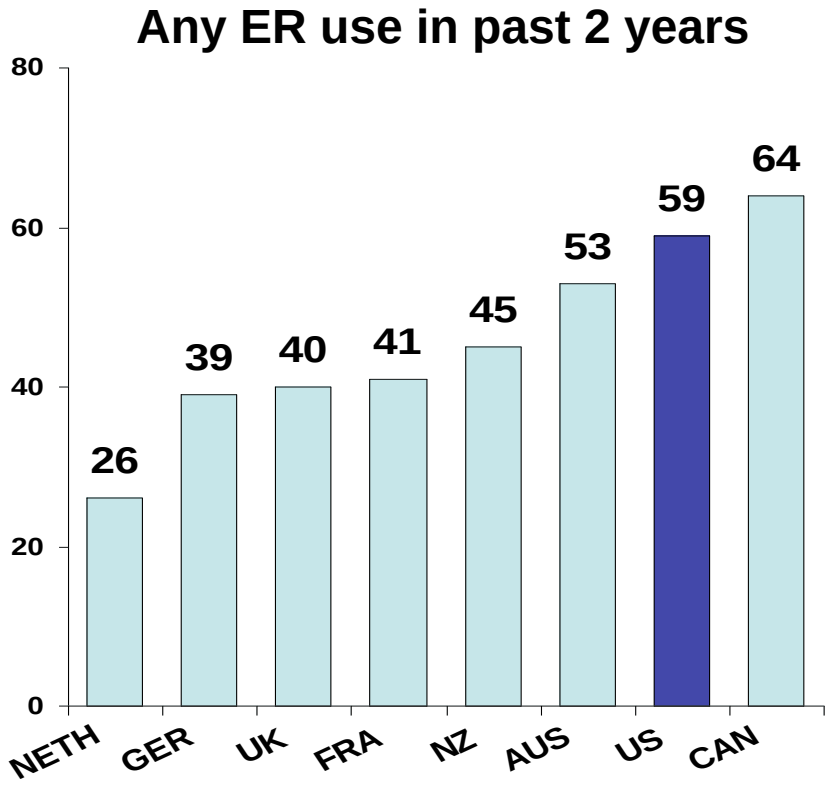
Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Access to Doctor When Sick or Needed Care, 2008

Base: Adults with any chronic condition

Percent





Data: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults
Source: C. Schoen et al., "In Chronic Condition: Experiences of Patients with Complex Healthcare Needs in Eight Countries, 2008", *Health Affairs* Web Exclusive, November 13, 2008.

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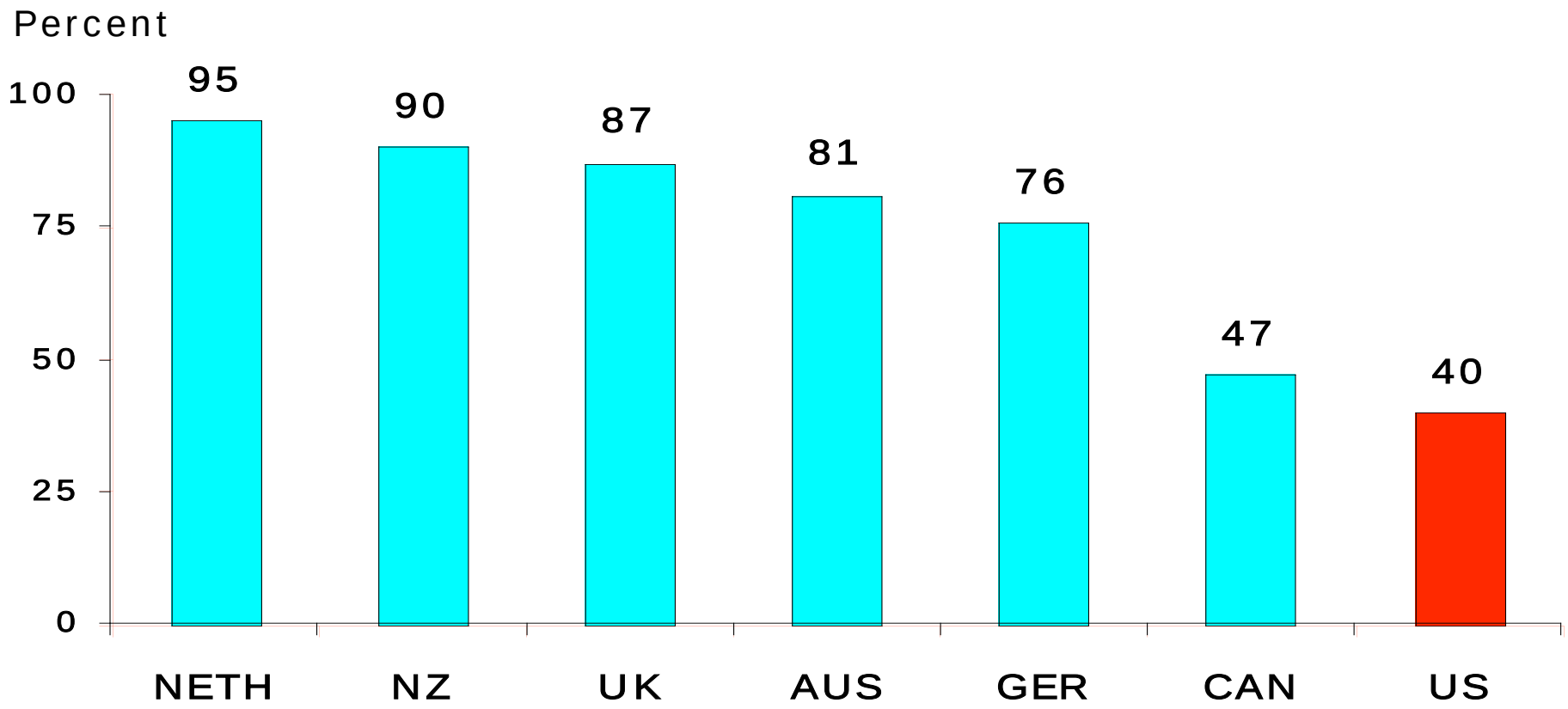
Primary Care Doctors: Practice Has Arrangement for After-Hours Care to See Nurse/Doctor, 2006



Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians (Schoen et al., "On The Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Nov. 2, 2006).

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Toward Accessible, Accountable, Patient-Centered Primary care

- **Patient-Centered "Medical Home" Principles**
  - **Enhanced access to care – including after hours**
  - **Personal relationship – physician and care team**
  - **Whole person orientation**
  - **Coordinated and integrated care**
  - **Safe and high-quality care (evidence-based, HIT, health)**
- **A "Systems Approach": Access, Quality and Efficiency**
  - **Payment to support value and teams; patient-centered**
  - **Information and team infrastructure; shared resources**
  - **Integration across sites of care: virtual and more formal**
  - **Accountable: quality and outcome benchmarks to improve**

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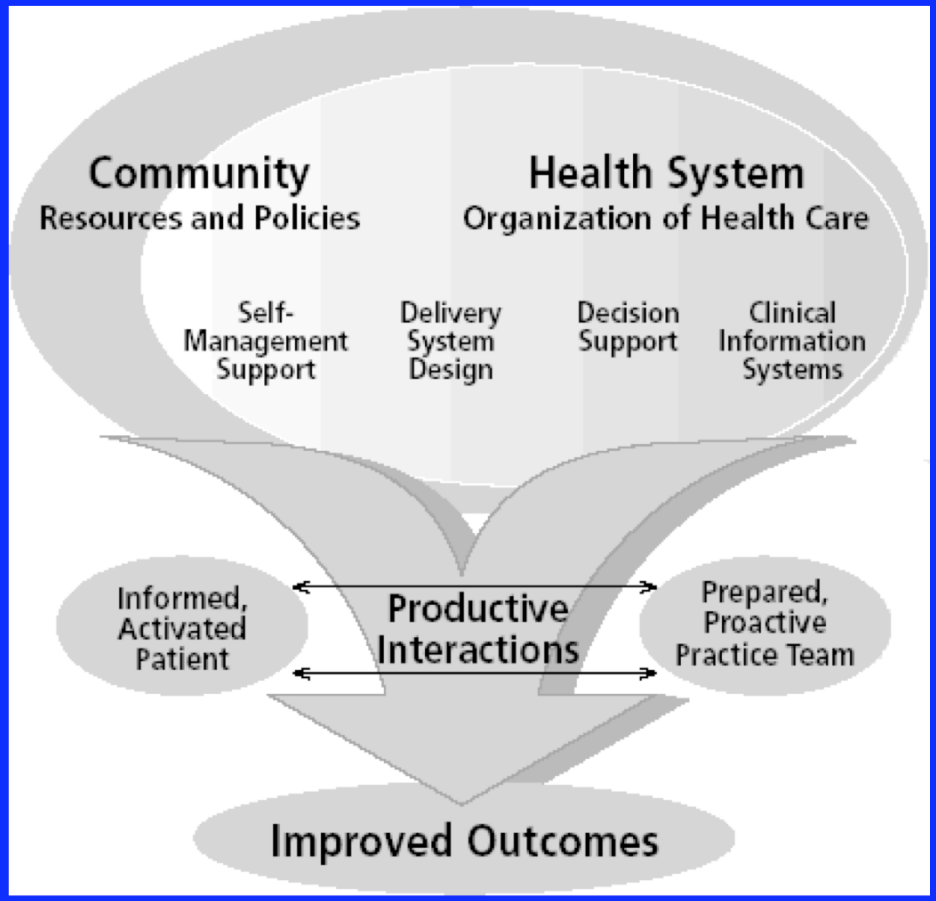
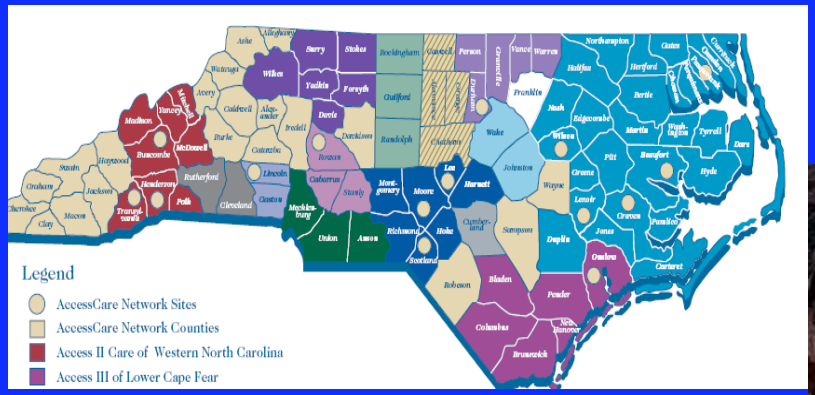
Engaging Patients and Managing Care Chronic Care Model and Medical Home Fit Together



- **Chronic care model requires a team, patient-centered approach, IT support**
- **Country initiatives around disease management or frail elderly have elements related to building medical homes**

Medical Home System Examples Exist in U.S.: More than One Model of Medical Home

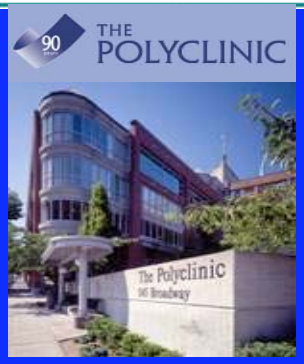


Community Care of North Carolina

GroupHealth

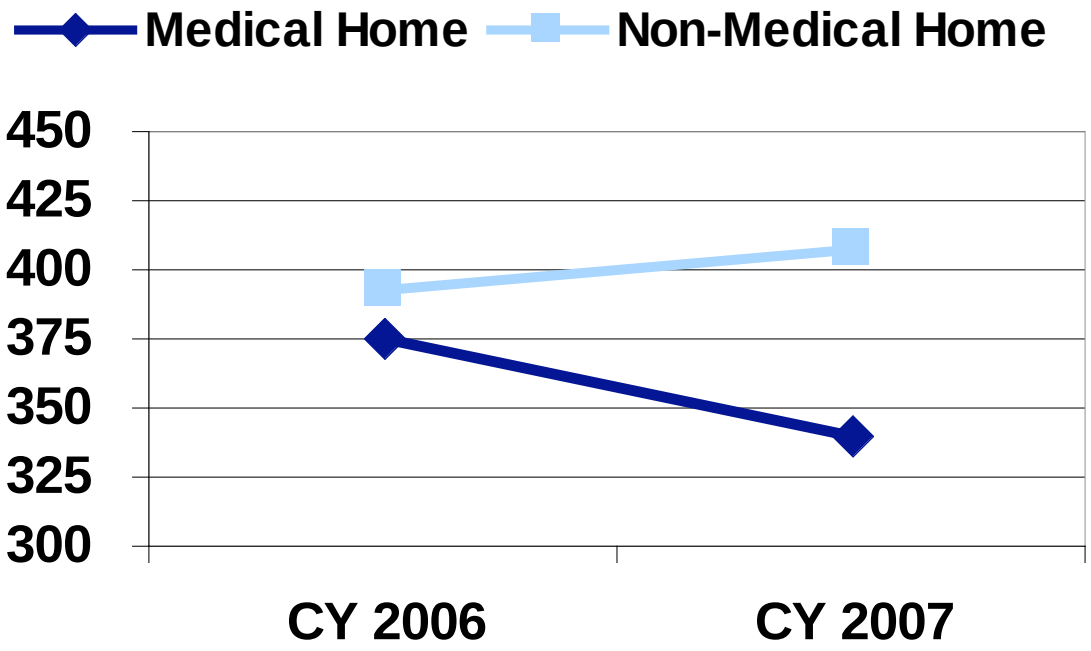
ALASKA NATIVE MEDICAL CENTER

DENVER HEALTH
Level One Care for ALL

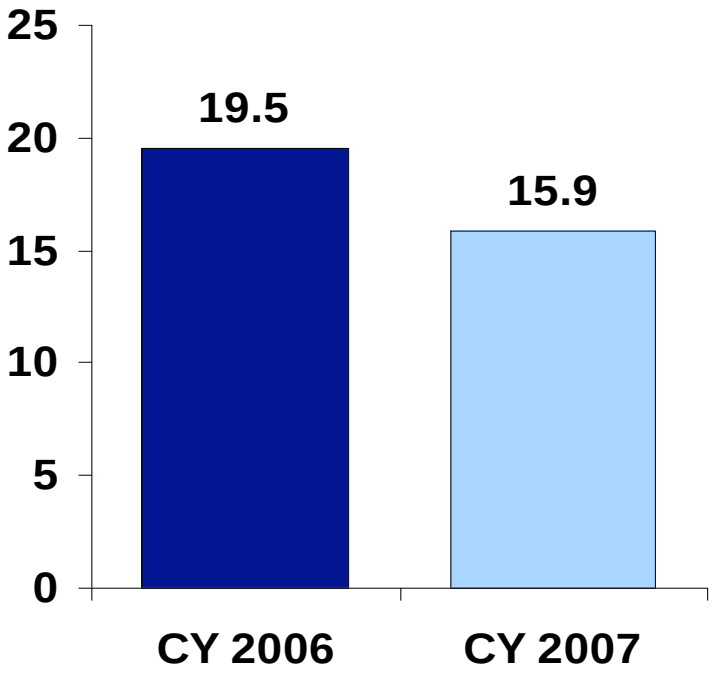


Geisinger Medical Home Sites and Hospital Admissions/ Readmissions

Hospital admissions per 1,000 Medicare patients



Readmission rates for all Medical Home Sites



- **20% reduction in hospital admissions**
- **18.5% reduction in hospital readmissions**
- **7% total medical cost savings**

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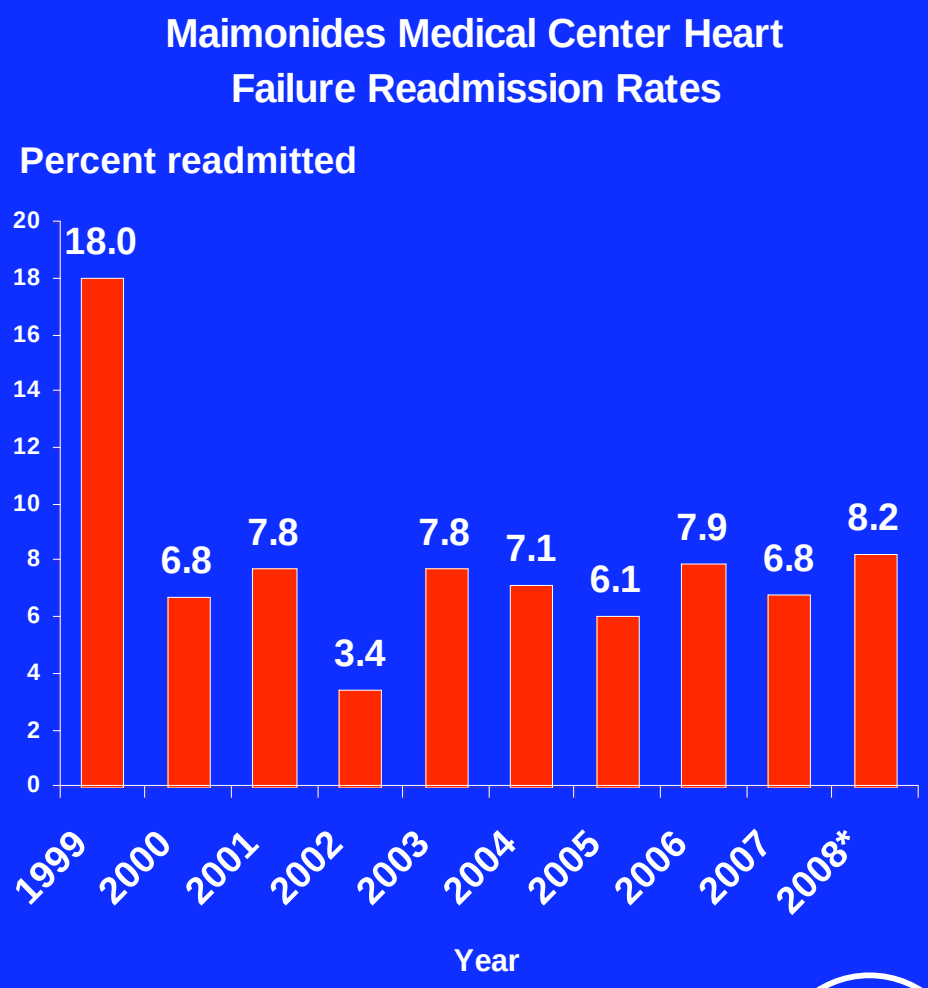
Source: Geisinger Health System, 2008.

Organizing the Care System: Managing Care Coordination and Care Transitions

- **MedPAC report estimates 75% of Medicare 30-day readmissions are potentially preventable**
- **Maimonides Medical Center (NY) reduced readmissions by over 50% through team-based inpatient care and with transition post-discharge**
- **Requires "system" approach**
- **Incentives work against reducing rates**



Source: MedPAC : Promoting Greater Efficiency in Medicare, June 2007; Quality Matters: Mortality Data and Quality Improvement, Sept./Oct. 2007, The Commonwealth Fund, Vol. 26; Maimonides Medical Center 2008.

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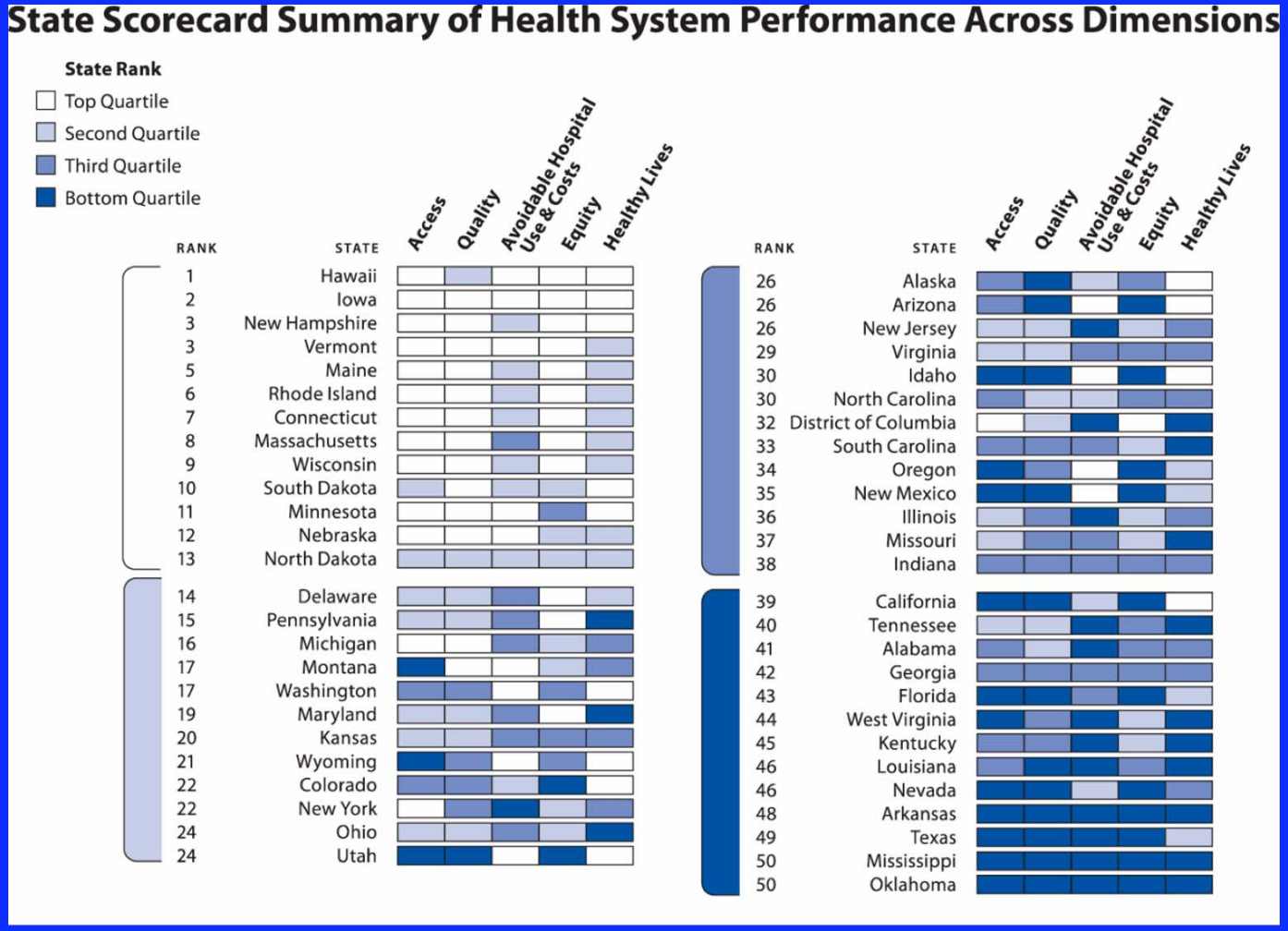
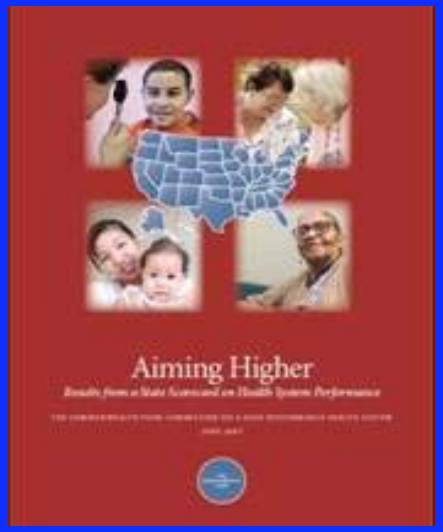
Aiming Higher: State Scorecard on Health System Performance

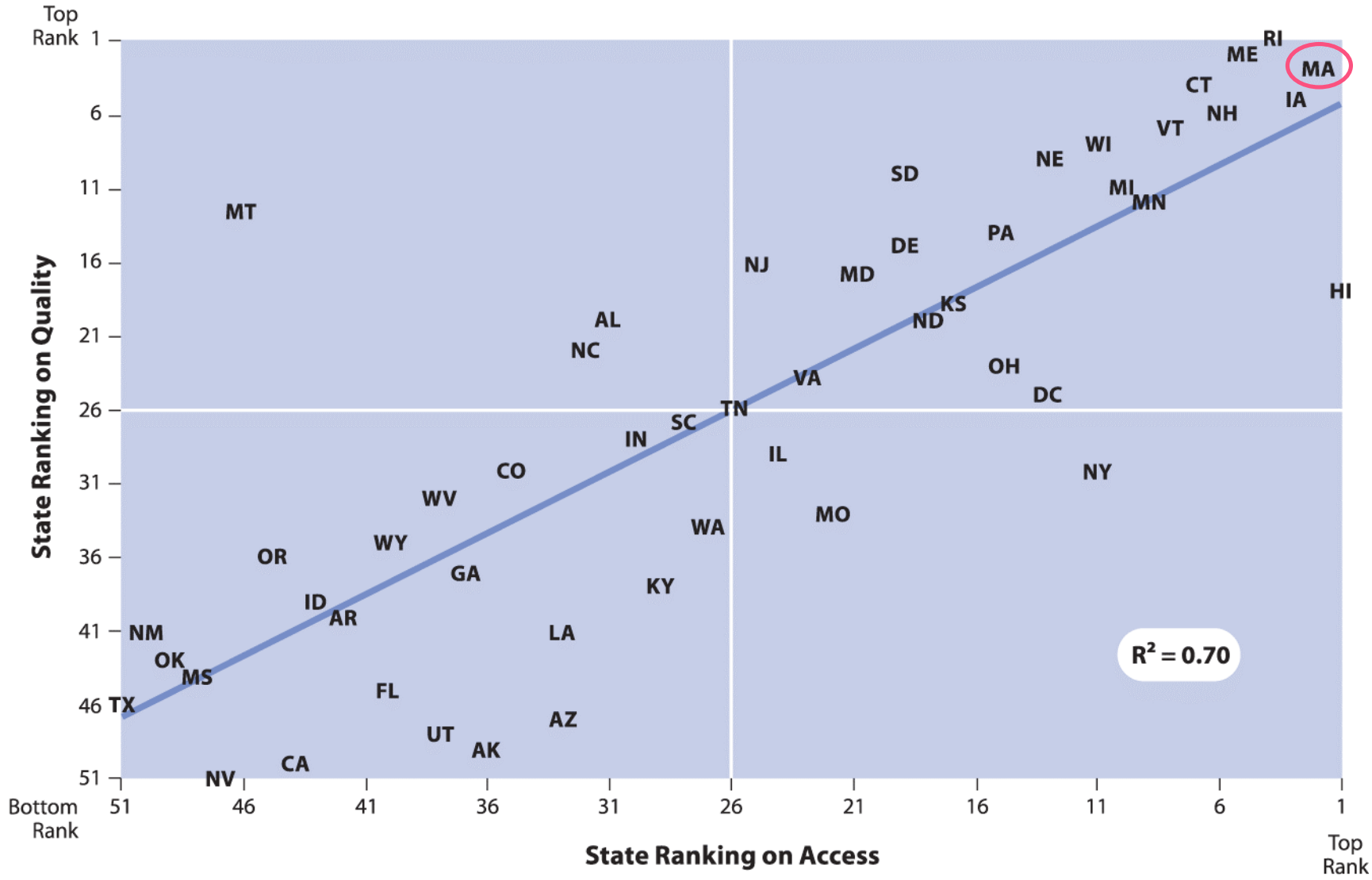




- **State ranks**
- **32 indicators**

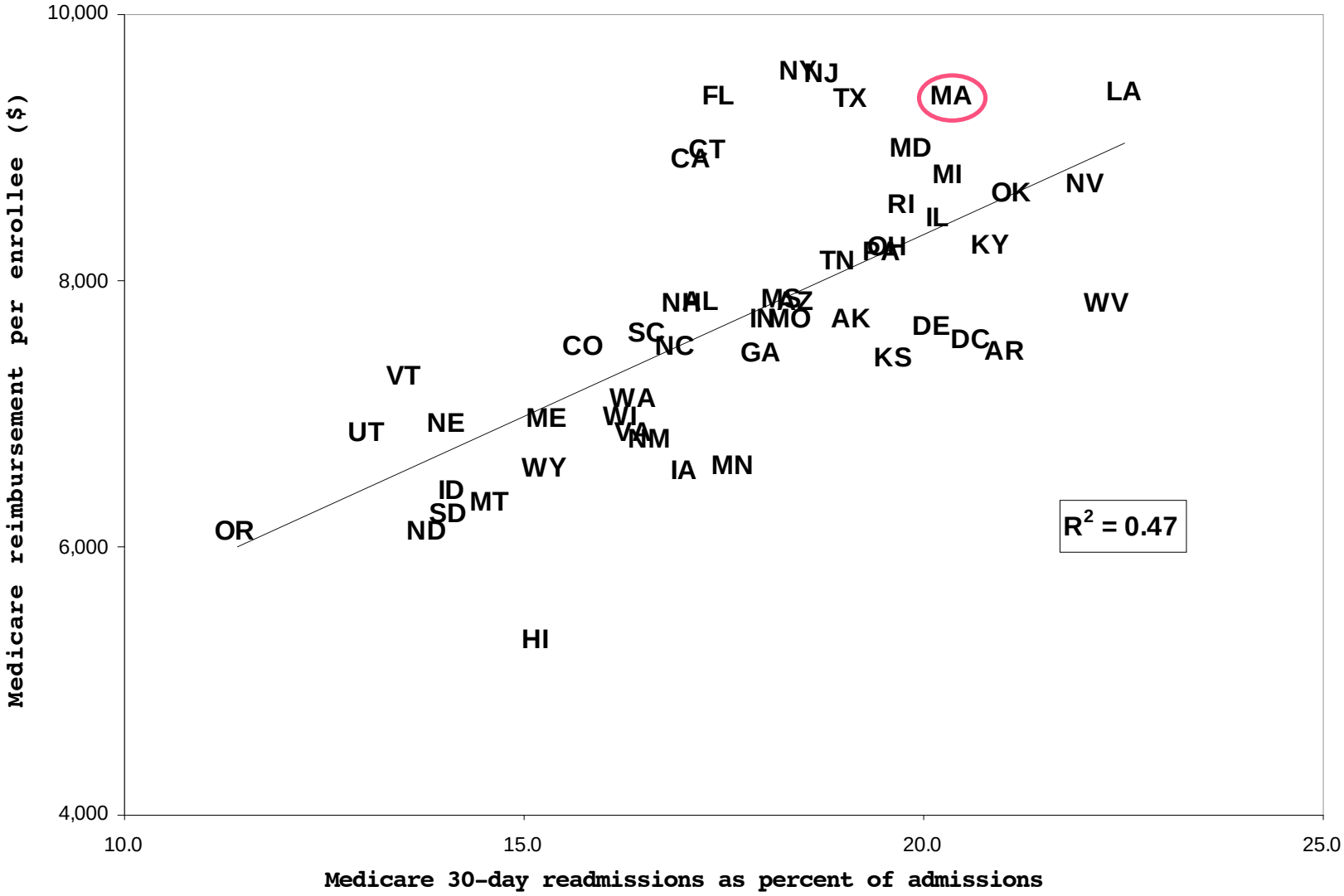
Source: Commonwealth Fund State Scorecard on Health System Performance, 2007

State Ranking on Access and Quality Dimensions



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

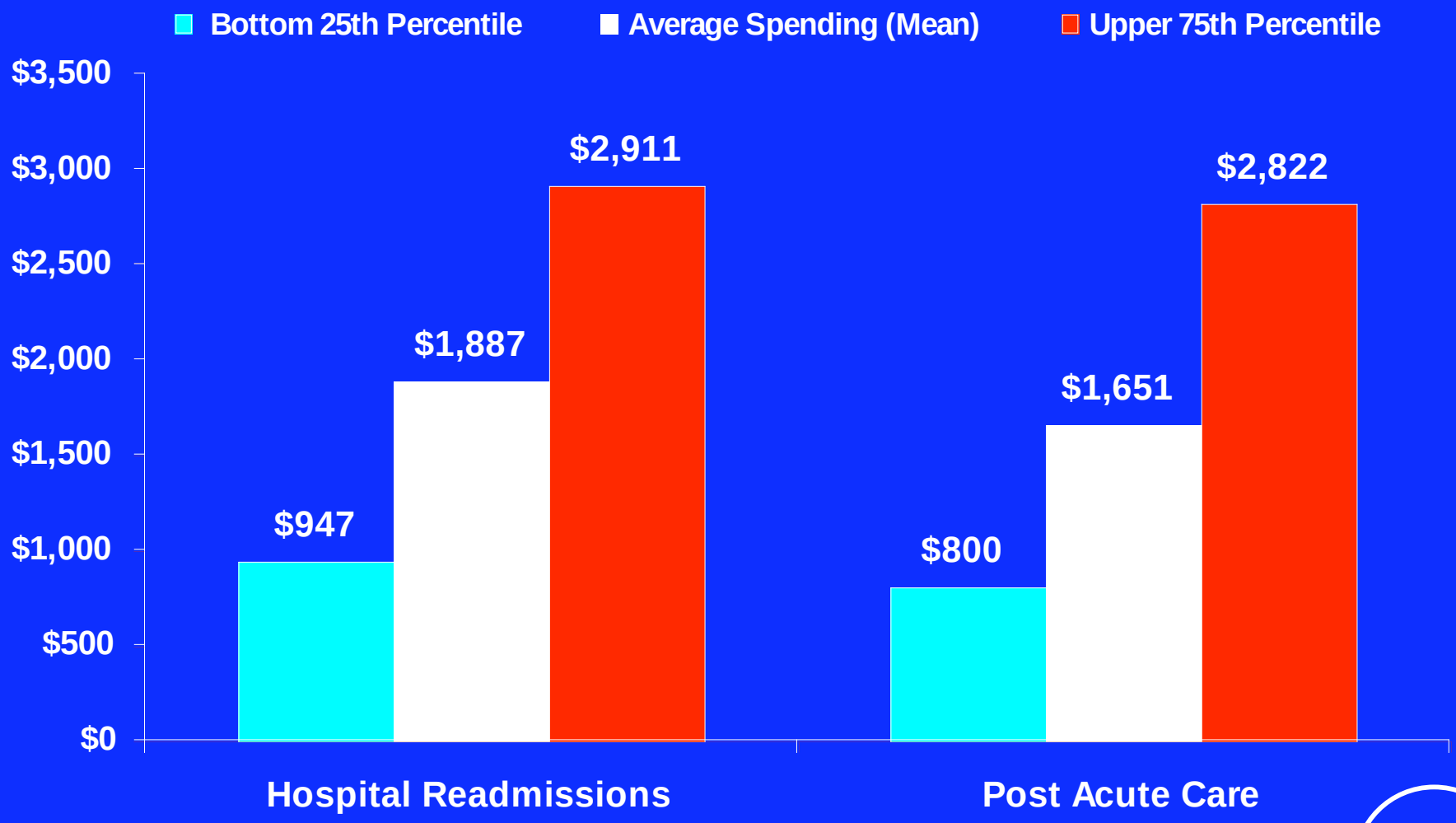
Medicare Annual Cost and 30-Day Readmissions by State, 2006



DATA: Medicare readmissions – 2006 Medicare 5% SAF Inpatient Data; Medicare reimbursement – 2006 Dartmouth Atlas of Health Care

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009, forthcoming.

Average Risk-Adjusted Standardized Spending for Hospital Readmissions and Post Acute Care After Coronary-Artery Bypass, 2001-2003



Source: Hackbarth, G et al. "Collective Accountability for Medical Care — Toward Bundled Medicare Payments."
N Engl J Med 359:1, July 3, 2008, Page 4

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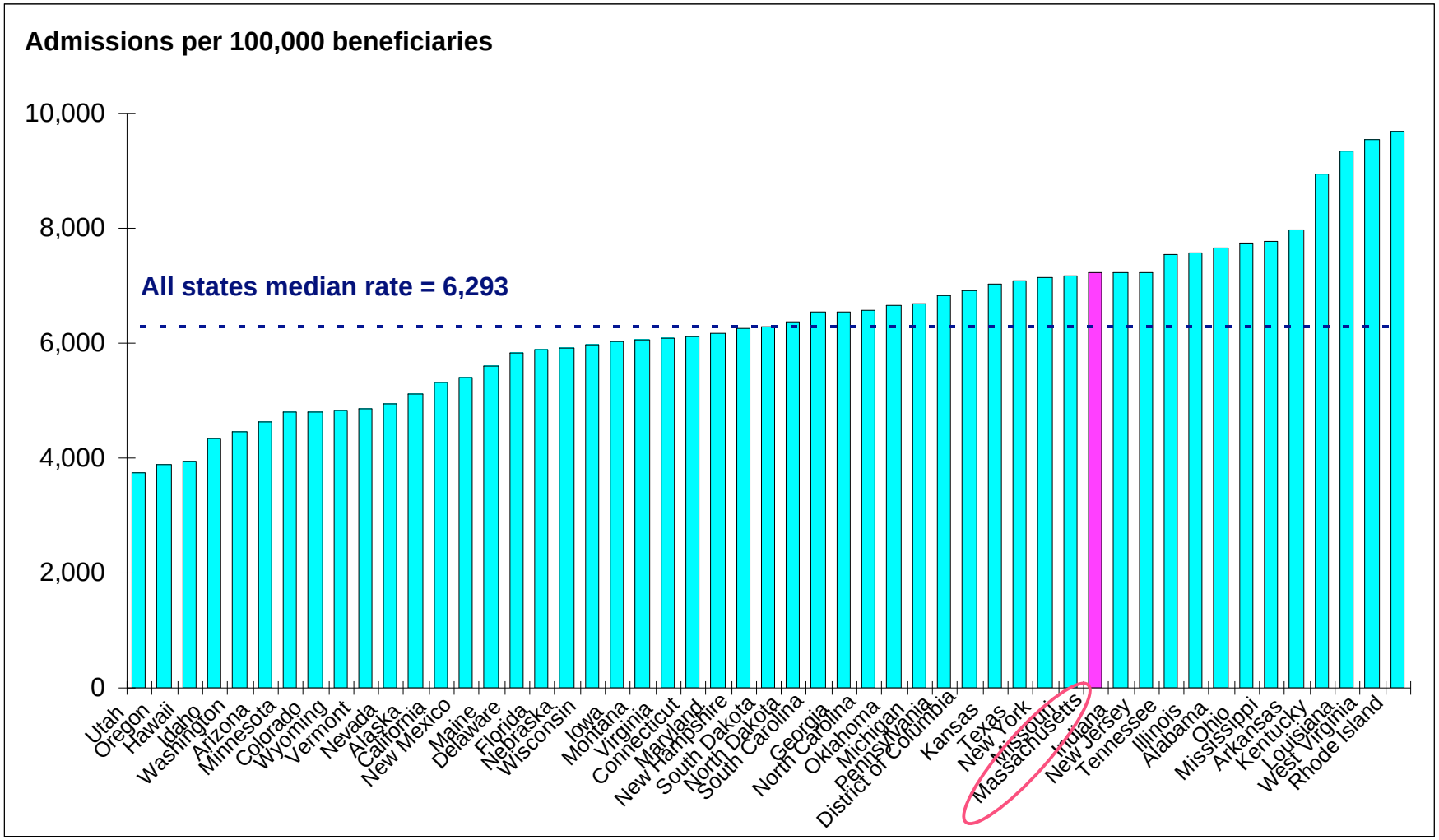
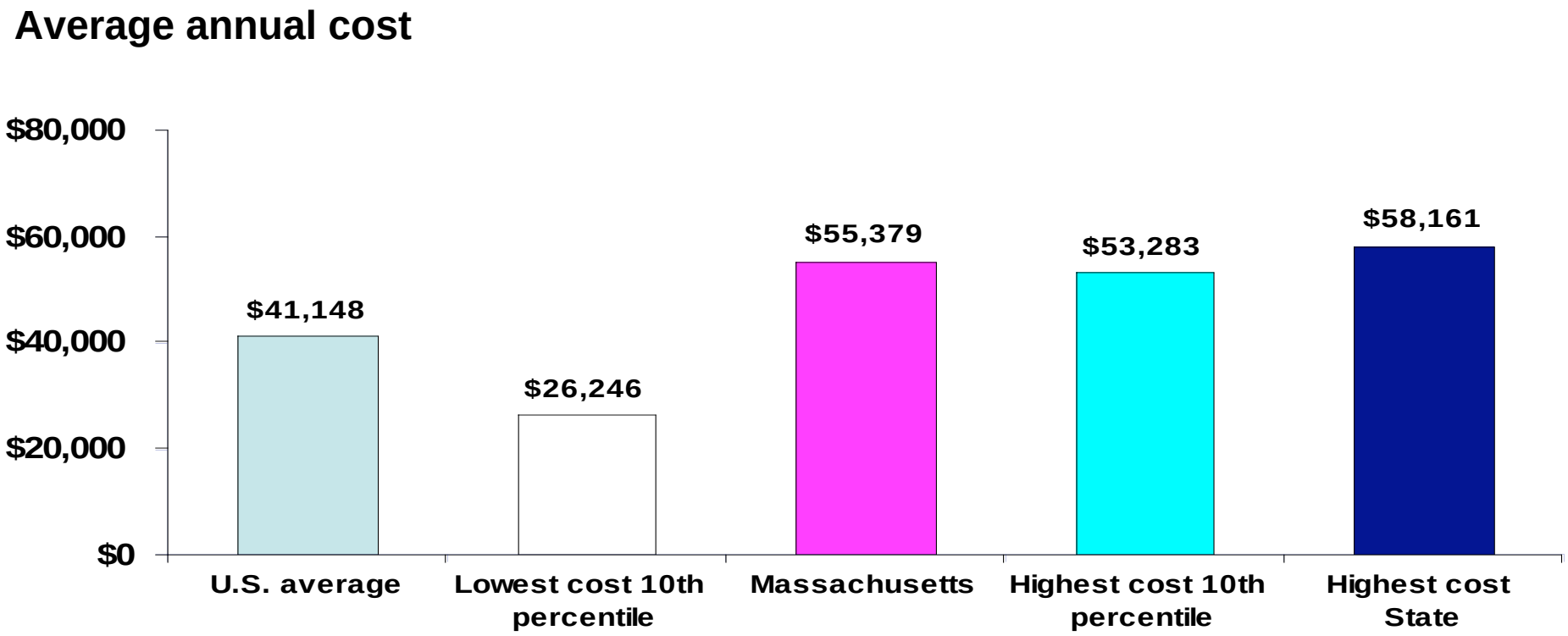
State Rates of Hospital Admissions Among Medicare Beneficiaries for Ambulatory Care Sensitive Conditions, 2006



DATA: Medicare SAF 5% Data from the Chronic Condition Data Warehouse (CCW)

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009 forthcoming

State Variation: Annual Costs of Care for Medicare Beneficiaries with Three Chronic Conditions (Diabetes, Heart Failure, and COPD), 2006



DATA: Medicare SAF 5% Data from the Chronic Condition Data Warehouse (CCW)

SOURCE: Analysis by G. Anderson and R. Herbert, Johns Hopkins University.

Align Incentives To Improve Value

- **Reform payment and align incentives**
  - **Current incentives reward quantity not quality or efficiency**
  - **Undervalue primary care**
  - **Complexity; lack of coherent payment or pricing policies**
- **Payment reform needed to stimulate and support care system innovation**
  - **More “bundled” payments with accountability**
  - **Strengthen primary care; “medical homes” capacity**
- **Challenges**
  - **Investment necessary to achieve returns**
  - **Fragmented payers/risk pools; fragmented care system**
  - **Poor information systems to inform, drive or assess**

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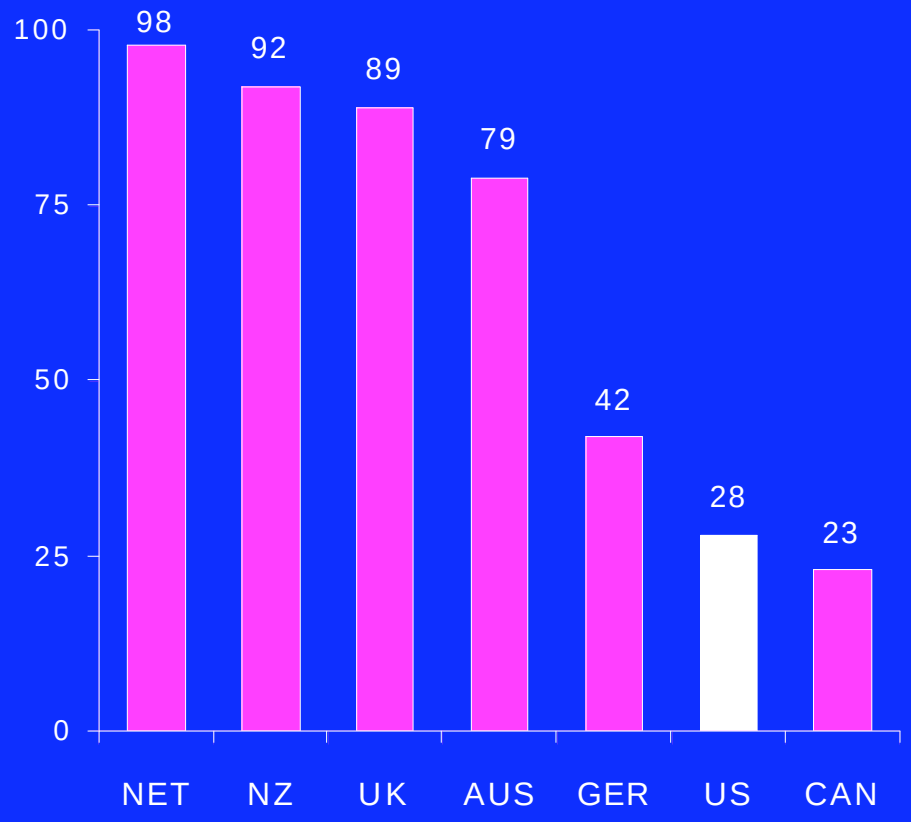
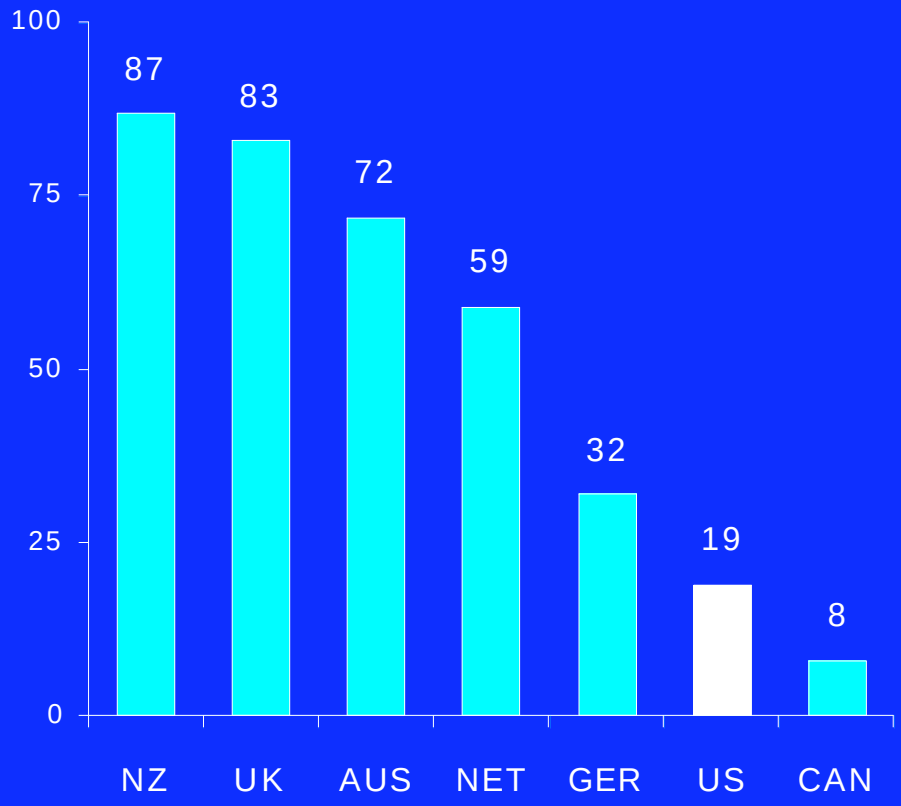
Where Are We on IT?

Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Have Advanced IT Capacity

Percent reporting EMR



Percent reporting 7 or more out of 14 functions*



*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians (Schoen et al., "On the Front Lines of Care," *Health Affairs* Nov. 2, 2006.

Why Invest in E-Health? Registries? Denmark Physicians and Patients Example

- **Doctors:**
  - **50 minutes saved per day in GP practice**
  - **Information ready when needed**
  - **Telephone calls to hospitals reduced by 66%**
  - **E-referrals, lab orders**
  - **Patient e-mail consultation, Rx renewal**
- **Patients:**
  - **Reduced waiting times, greater convenience**
  - **Info about treatments, number of cases**
  - **Patients access to own data**
  - **Preventive care reminders**
  - **Information about outcomes**

Source: I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.

Accountable Leadership and Public/Private Collaboration

- **Leadership essential to develop infrastructure for markets to work**
  - **National targets, benchmarks of high performance**
  - **Comparative effectiveness**
  - **Health Information Technology standards and exchange**
  - **Unified health and cost data systems: goals and measures**
- **Public/Private Collaboration for coherent policies**

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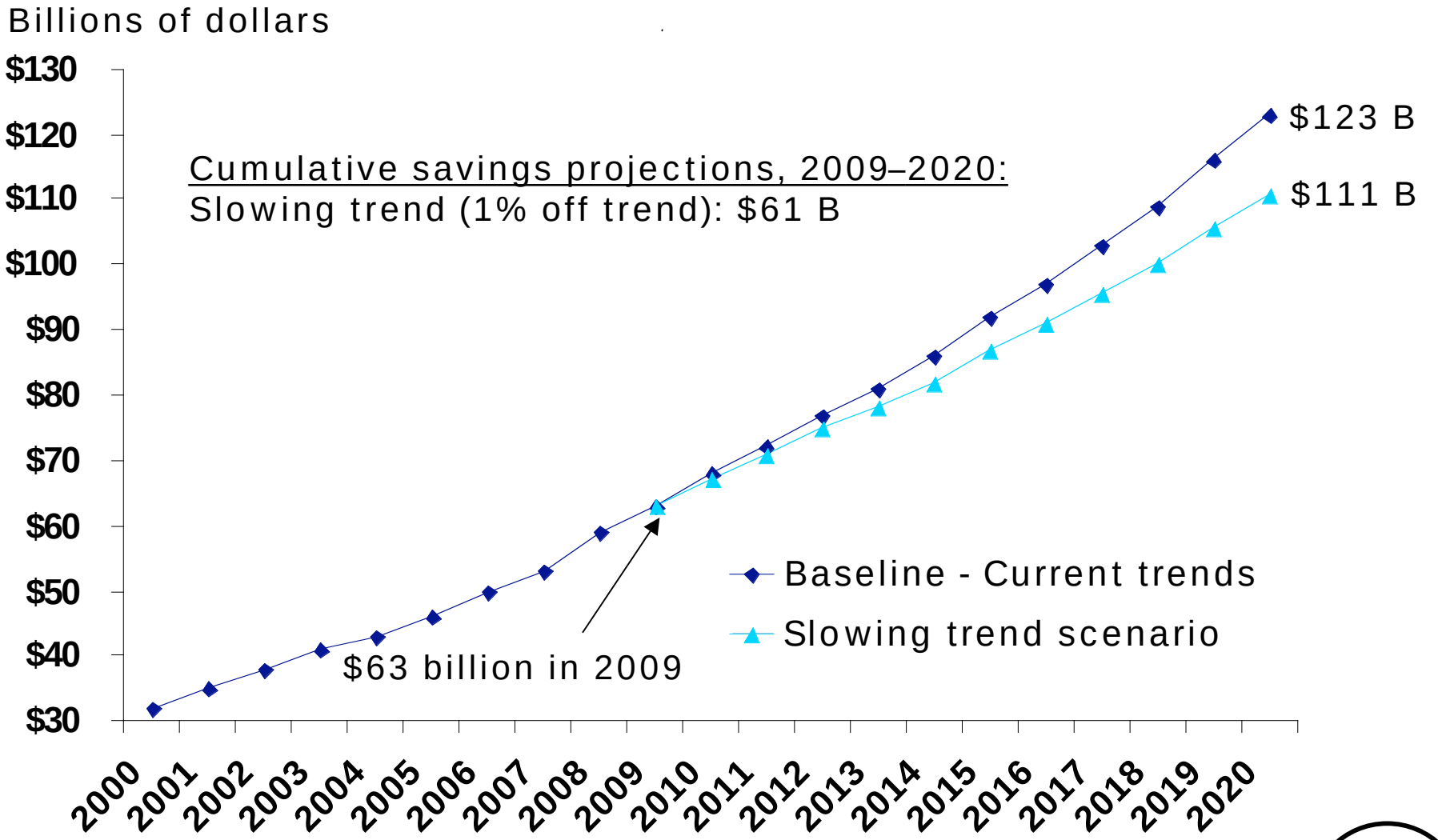
Bending the Massachusetts Cost Curve: Growth in Massachusetts Total Health Expenditures Under Two Scenarios



Data: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007. 2005-2020 data are projected based on projected per capita health expenditures.
Adapted from Davis, Schoen et al. Slowing the Growth of U.S. Health Care Expenditures: What are the Options?, Commonwealth Fund January 2007.

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Toward High Performance Agenda for Change

- **Comprehensive "system" approach required**
  - **To end fragmentation (financing and delivery)**
  - **To improve value while achieving savings**
- **Coverage foundation essential**
  - **Access, payment reforms, and focus on outcomes; foundation and catalyst**
- **National leadership and public/private collaboration essential**
  - **Medicare participation key to coherent approaches**
  - **Federal policies matter**
- **States can lead to innovate and raise benchmarks**

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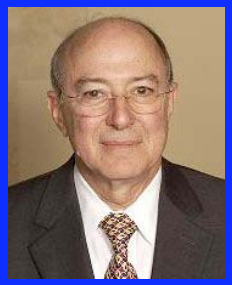
Thank You!

Karen Davis
President
The Commonwealth Fund, kd@cmwf.org

Sara Collins, Assistant Vice President, src@cmwf.org



Stephen C. Schoenbaum, M.D., Executive Vice President and Executive Director, Commission on a High Performance Health System, scs@cmwf.org

Stu Guterman, Senior program Director, sxg@cmwf.org

Visit the Fund's website at
www.commonwealthfund.org

Sabrina How, Senior Research Associate

skh@cmwf.org

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